State Corporation Commission
Bureau of Insurance
Life and Health Division
Office of the Managed Care Ombudsman
Post Office Box 1157
Richmond, VA 23218

Internet Version

Inquiry Form
Managed Care Health Insurance Plan (MCHIP)

Complete this form if you want help with an appeal.

Name:_____
Birthdate _____ Sex _____
Address_____
City _____ State _____ ZIP Code_____
Work Phone Number (___)_____ Home Phone Number (___)_____

If this appeal is not for you, please tell us who is and explain your relationship:
_____

Are you covered by Medicare _____? Medicaid _____?

MCHIP Name _____
Address _____
City _____ State _____ ZIP Code _____

MCHIP Enrollee Policy Certificate or ID Number_____

Type of MCHIP

_____HMO (Health Maintenance Organization) _____PPO (Preferred Provider Organization)
_____POS (Point of Service) _____Other _____

Source of Coverage Group _____ Individual _____

If group coverage, name and address of employer:
_____

Nature of Appeal – **Check all box(es) that apply:**

- ☐ Claim
- ☐ Underwriting
- ☐ Administrative
- ☐ Surgical Procedure
- ☐ Emergency Room Services
- ☐ Prescription Medication
- ☐ Denial of Treatment
- ☐ Availability of Provider/Facility
- ☐ Out-of-Network Care
- ☐ MCHIP Policy/Procedure
- ☐ Dental/Oral Surgery
- ☐ Other _____

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Briefly describe the circumstances regarding your appeal.

_____

_____

_____

_____

_____

Please give a brief summary of the MCHIP's response to any appeal you have made.

Date Phone/Letter MCHIP Staff Name and Title MCHIP Response

_____

_____

_____

Please name other parties you have contacted. (Example: other state agencies, an attorney, etc.)

_____

_____

I am enclosing copies of correspondence or other documents (correspondence from providers, and correspondence to or from the MCHIP) relating to this matter that may help the Bureau of Insurance (BOI) in its evaluation of my inquiry. I understand and agree that a copy of this form and any information I provide may be forwarded to the MCHIP or one of its contracted providers in order for the BOI to assist me. I also agree that by signing this form, I authorize the BOI to obtain any additional information, including copies of my medical records, required to assist me.

_____ _____

Signature Date

_____

Signature of Insured/Enrollee (if different from above)

Disposition

- ☐ Referred to CSS
- ☐ Referred to VDH
- ☐ Resolved
- ☐ Referred to External Review
- ☐ Referred to _____

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